PASSBACK STATEMENT OF
MADHULIKA AGARWAL, M.D., M.P.H.
DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND SERVICES
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON VETERANS' AFFAIRS

March 27, 2014

Good Morning Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee. Thank you for inviting me here today to present our views on ten bills that would affect Department of Veterans Affairs (VA) health programs and services. Joining me today is Mr. Philip Matkovsky, Assistant Deputy Under Secretary for Health for Operations and Management and Ms. Renée L. Szybala, Acting Assistant General Counsel.

We do not yet have cleared views on H.R. 3387, H.R. 4198, and H.R. 2974. Also, we do not yet have estimated costs associated with implementing several of the bills. We will forward these views and any estimated costs to you as soon as they are available.

H.R. 183

H.R. 183 would require the Secretary, within 120 days of enactment, to commence a pilot program for a 5-year period to assess the effectiveness of using service dog training programs to address post-deployment mental health and posttraumatic stress disorder (PTSD) symptoms and produce specially-trained service dogs for Veterans. The bill would require the Secretary to conduct the pilot program at a minimum of three and not more than five VA medical centers.

The bill also includes provisions concerning the service dogs themselves and the personnel assigned to the program. The bill requires VA to ensure that each service dog in training have adequate temperament and health clearances. Dogs in animal shelters or foster homes are not to be overlooked as candidates. The Secretary must also ensure that each service dog in training is taught all essential commands and behaviors required of service dogs. The bill would require each pilot program site to have certified service dog training instructors with preference given to Veterans who have graduated from a residential treatment program and are adequately certified in service dog training.

VA supports the identification of effective treatment modalities to address PTSD and other post-deployment mental health symptoms; however, VA does not support the specific provisions in H.R.183 because the bill focuses on the training of the dog as opposed to what we believe is the goal of this legislation, which is finding better ways to improve the health of this Veteran population by exploring the efficacy and effectiveness of certain treatments, specifically Animal Assisted Therapy or Animal Facilitated Therapy, that will prepare dogs to become service dogs for Veterans.

The restrictions that would be imposed by H.R. 183 regarding the criteria for the selection of dogs and the qualifications required of the trainers pose significant challenges to the goal of this legislation. Provisions requiring medical centers to ensure appropriate areas for the “art and science” of service dog training are focused on ensuring the quality of the rigorous training regimen required to produce well-trained service dogs as opposed to the therapeutic activities that Animal Assisted Therapy or Animal Facilitated Therapy may provide if appropriately administered as a component of a comprehensive mental health treatment program. This specialized and rigorous training regimen for the service dogs falls outside the purview and mission of VA health care and well beyond the scope of corporate expertise. These same concerns are extended to provisions related to the design of the pilot, such as the acceptance of animals from shelters, educating participants about service dog training methodologies, practical hands-on training and grooming of service dogs, ensuring mastery of all essential commands, and residency requirements for dogs.

The VA Palo Alto Health Care System (Menlo Park Division), in collaboration with Bergin University of Canine Studies, established the Palo Alto Service Dog Training Program in July 2008. The Palo Alto program is not an example of VA independently and internally training or producing service dogs for Veterans. The dogs involved in the Palo Alto program were trained to become service dogs by an external organization, accredited by Assistance Dogs International, over an extended period of time and subject to standards as adopted and applied by that organization. The Palo Alto program, using VA facilities for the therapy portion but relying completely on the external organization's dog training program, focuses on basic obedience (e.g., commands such as "sit," "stay," and "heel") and public access skills (sensitizing dogs to different environments) to prepare the dogs to become service dogs for disabled persons because VA does not have the expertise, experience, or resources to develop independent training criteria or otherwise train or produce safe, high-quality service dogs for Veterans. Such training is highly specialized and includes the training of the Veteran who is to receive the service dog.

Cost estimates for this bill were not available at the time of the hearing.

H.R. 2527

H.R. 2527 would amend 38 United States Code (U.S.C.) 1720D to extend VA's counseling and care benefits for treatment of sexual trauma to Veterans who experienced sexual trauma while serving on inactive duty for training. Current authority covers only sexual trauma that a Veteran experienced while serving on active duty or active duty for training.

H.R. 2527 would also define the term "Veteran," with respect to inactive duty training described in section 1720D(a)(1), as amended by the bill, to include an individual who is not eligible for VA health care benefits (under 38 U.S.C. chapter 17), and who, while serving in the reserve components of the Armed Forces, performed such inactive duty training but did not serve on active duty.

VA supports this bill as it would close a gap in eligibility for military sexual trauma-related counseling and care. The current gap in eligibility arises when sexual

trauma occurs during weekend drill trainings for members of the National Guard or Reserves. Weekend drill trainings are inactive duty training. Unless a Veteran who experienced sexual trauma while serving on inactive duty for training is eligible to enroll in VA's health care system and receive needed care under VA's medical benefits package, VA lacks current authority to treat the Veteran for conditions resulting from that trauma.

VA anticipates this bill will require minimal additional funding.

H.R. 2661

H.R. 2661 would require the Secretary, not later than 180 days after enactment, to implement a standardized policy to ensure that enrolled Veterans are able to schedule primary care appointments within 7 days, and specialty care appointments within 14 days, of the date such appointment is requested by the Veteran or the Veteran's provider. In addition, the Secretary would be required to ensure the policy is not subject to interpretation or prone to scheduling errors and is able to provide the Secretary with reliable data regarding the length of time Veterans wait for appointments. The bill would also require VHA, in carrying out the policy, to use uniform procedures and to issue detailed guidance to Directors of Veterans Integrated Service Networks (VISN) to ensure consistent implementation at each VA medical center (VAMC) and other related VA facilities. The Secretary would be required to ensure that only VA employees, who have completed required training, are allowed to schedule medical appointments and that annual performance reports of each VISN's performance under the policy are made public.

H.R. 2661 would also require the Secretary, not later than 180 days after enactment and each 180-day period thereafter, to assess the resources of each VISN to determine the ability of the VISN to meet its scheduling requirements. To ensure that each VISN meets the scheduling requirements of its enrollees, the Secretary would be authorized to reprogram funds and to allocate or transfer staff and other resources within VHA and the VISN; however, Congress would need to be notified of any such reprogramming.

The bill would further require the Secretary to direct each VAMC to provide oversight of telephone access and to implement the best practices outlined in VHA's Telephone Improvement Guide including, at a minimum, practices to ensure calls are answered in a timely manner and that patients' messages are returned with a call within 24 hours. Each VAMC's call center would also need to be properly staffed to meet the demands of its patient-population.

Finally, H.R. 2661 would require VA's Office of Inspector General, in consultation with Veterans Service Organizations, to submit a detailed annual report to Congress on VA's progress in implementing the requirements of the bill.

VA does not support H.R. 2661. VA continues to make progress in the reliability of measuring and reporting waiting times. This process is heavily dependent on the software, technology and business processes available at the time. Mandating the timeframe within which a patient must receive an appointment is ill-advised because the process of scheduling is multi-factorial, and flexibility is required to ensure that scheduling occurs in a manner that is in line with clinical operating standards, which can evolve over time. This also extends to clinical contacts made by telephone. We also are uncertain of the basis for the inflexible timetables that would be mandated by H.R. 2661. We would be interested in discussing this issue with the Committee, including the need for flexibility while ensuring Veterans receive access to high-quality health care.

VA believes the telephone-related elements of the bill state valuable principles but could conflict with our ongoing efforts. The practices outlined in the Telephone Improvement Guide are currently being tested at both the VISN and facility level. In addition, three VISNs are investigating the use of specific communication models to assess the most effective approach by which to provide Veterans with responsive, available telephone service. It may be that these models will prove more efficient and preferable to what is used now or even to what would be required by H.R. 2661. Similar to scheduling procedures and other clinical operational matters, we believe codifying in law the details of how VA communicates with our patients is ill-advised. Once in statute, such terms could well end up preventing VA from identifying and using newer and more effective mechanisms and procedures that better align with clinical operational and clinical practice standards.

VA is unable to estimate the cost of this bill.

H.R. 2974

H.R. 2974 would amend 38 U.S.C. 111(b)(1) to ensure beneficiary travel eligibility for Veterans whose travel to a specialized outpatient or residential program at a VA facility for treatment or care for military sexual trauma. The bill would define the term "military sexual trauma" in 38 U.S.C. 111 to mean "psychological trauma, which in the judgment of a Department mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty or active duty for training;" and the bill would define the term "sexual harassment" to mean "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character." The amendments made by this legislation would apply with respect to travel occurring after enactment.

VA is currently reviewing this bill and will provide a position upon completion of this review. As a technical matter, we note that the bill purports to add a new subsection (g) to section 111 of title 38 U.S.C. We believe the drafters intended to add a new subsection (h) to section 111 instead, as the bill makes no mention of striking the current subsection (g) in section 111.

Cost estimates for this bill were not available at the time of the hearing.

H.R. 3180

H.R. 3180 would authorize VA to contract with, or award a grant to, a state for residential care for Veterans in a state home without triggering the recapture of the state home construction grants previously awarded to the state for that home. The term "residential care" is not defined in title 38 U.S.C. For purposes of the community residential care program, the term "community residential care" is defined in 38 CFR § 17.62 to mean "the monitoring, supervision, and assistance, in accordance with a statement of needed care, of the daily living activities of referred Veterans in an

approved home in the community by the facility's provider." However, VA cannot provide grants or contracts for such care under that program. See 38 U.S.C. § 1730(b)(3). Nevertheless, under another authority, 38 U.S.C. § 1720(g), VA may contract with appropriate entities to provide specialized residential care and rehabilitation services to an Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) Veteran, who VA determines suffers from a traumatic brain injury, has an accumulation of deficits in activities of daily living and instrumental activities of daily living, and because of these deficits, would otherwise require admission to a nursing home even though such care would generally exceed the Veteran's nursing needs. If H.R. 3180 is enacted, VA could contract with states to provide residential care in a state home under section 1720(g) without triggering the recapture of a grant.

VA does not support enactment of this bill because it would authorize VA to contract with state homes without triggering the recapture of the state home construction grants previously awarded to the state for that home for care for which they currently receive VA per diem payments under the VA State Home Grant Program. State Veterans homes can provide any combination of three levels of care: nursing home, domiciliary, and adult day health care without being subject to the recapture of any VA construction grant. Domiciliary care is essentially specialized residential care that VA may contract for under 38 U.S.C. § 1720(g). State Veterans homes that provide domiciliary care should thus be capable of providing specialized residential care and rehabilitation services for OEF/OIF Veterans who suffer from a traumatic brain injury.

There are no current requests from states for state Veterans homes to provide residential care under VA contract or grant. Thus, VA cannot predict future costs that would be associated with this bill.

H.R. 3508

H.R. 3508 would amend 38 U.S.C. 7401(3) to include hearing aid specialists among personnel who may be appointed by VA as the Secretary may find necessary for the health care of Veterans. The bill would also amend 38 U.S.C. 7402(b) to specify qualifications for hearing aid specialists, including requiring the individual "hold an

associate's degree in hearing instrument sciences, or its equivalent, from a college or university approved by the Secretary, or have successfully completed a hearing aid specialist apprenticeship program approved by the Secretary," and "be licensed as a hearing aid specialist, or its equivalent, in a State." Hearing aid specialists who do not meet these requirements would still be eligible for appointment to a hearing aid specialist position if, during the 2 years prior to enactment of the bill, the individual "held an unrevoked, unsuspended hearing aid license, or its equivalent, in a State," and "worked as a licensed hearing aid specialist in a State."

In addition, H.R. 3508 would require VA, no later than 1 year after enactment and each year thereafter, to report to Congress on timely access to hearing health services and contracting policies with respect to providing hearing health services in non-VA facilities. VA would be required to include in the report VHA staffing levels of audiologists, health technicians in audiology, and hearing aid specialists; a description of performance measures with respect to appointments and care related to hearing health; average wait times for specified appointments; percentages of patients whose wait times fell within specified time frames; the number of patients referred to non-VA audiologists for initial hearing health diagnosis appointments and to non-VA hearing aid specialists for follow-up hearing health care; and VHA policies regarding referral to non-VA hearing aid specialists and how such policies will be applied under the Patient-Centered Community Care initiative.

Finally, H.R. 3508 would require VA, no later than 180 days after enactment, to update and reissue VHA Handbook 1170.02, *VHA Audiology and Speech-Language Pathology Services*, to reflect the requirements of this bill.

VA values the current contribution being made by hearing aid or instrument specialists to hearing loss treatment and evaluation services, however, VA does not believe this bill is necessary as the Secretary already has existing authority under 38 U.S.C. § 7401(3) to appoint such specialists if deemed necessary to support the recruitment and retention needs of the Department. In addition, the Secretary already has authority under 38 U.S.C. § 7402(b) to establish qualification standards for health care occupations, including establishing technical qualifications for hearing aid specialists. VA believes this bill's language unduly restricts the Secretary's latitude to

establish qualification standards under this authority, and that existing procedures for establishing qualifications standards under title 5 series 640 or hybrid title 38 are sufficient.

Also, VA is concerned that the lack of standardized educational or professional health licensure requirements could fragment hearing health care services and limit delivery of comprehensive hearing health care under the language in H.R. 3508.

A highly trained workforce is required to deliver comprehensive services and coordinate care in the VA health care system, given VA's mission to provide comprehensive patient-centered health care. Utilizing occupations that are limited in training and scope for comprehensive hearing health services under the proposed legislation would fragment the current high-quality health care delivery system, especially because Veterans frequently exhibit hearing loss in combination with other co-morbidities.

VA audiologists are doctoral-level professionals trained to diagnose and treat hearing loss, acoustic trauma and ear injuries, tinnitus, auditory processing disorders, and patients with vestibular complaints. VA provides comprehensive hearing health care services and employs both audiologists and audiology health care technicians who deliver care coordinated within the Patient Aligned Care Team (PACT). VA can appoint hearing aid specialists as audiology health technicians in job series 640 (health technicians) under title 5. VA currently employs 318 audiology health technicians (also commonly known as audiology assistants) who function under the supervision of audiologists. Some of these audiology health technicians are licensed as hearing aid specialists, although they are hired as health technicians whether or not they are licensed as hearing aid specialists.

Audiology health technicians, currently employed in audiology clinics as valued members of the audiology team and working under the direction of audiologists, have a broader scope of practice than the typical hearing aid specialist. VA developed this job series and associated core competencies for health technicians to provide efficient support services and assist audiologists in the provision of comprehensive hearing care. Examples of the scope of services include cerumen management, aural rehabilitation, hearing conservation and prevention of noise-induced hearing loss, tinnitus

management, hearing aids and other amplification technologies including implantable auditory devices, and management of Veterans' hearing health care with other health care disciplines in the context of their overarching patient-centered needs.

The VA audiology health technician has duties and responsibilities beyond those allowed by state law for hearing aid specialists. The hearing instrument specialist occupation has no consistent professional education requirements and no standardized internships resulting in highly-variable skill sets. In 33 states, only a high school education is required for hearing instrument specialist licensure. Nine states have no educational requirement and eight states require an associate's degree. As a result, based on hybrid title 38 grade-related education requirements, hearing instrument specialists are likely to be hired at low grades making less money working for VA than they would earn working in the retail business community where they are licensed to sell hearing aids. Hearing instrument specialists are licensed to sell hearing aids and are regulated primarily for their hearing aid sales roles. The license does not require professional education, clinical training, or experiential health care apprenticeships, and the licensure qualifications have not changed in many years. They are not part of any health care teams in the military, the academic or medical/professional school environment, or the hospital environment. Substituting the VA audiology health technician with a hearing instrument specialist would fragment hearing health care services and limit delivery of comprehensive hearing health care.

Finally, with respect to the treatment of "certain current specialists" in section 1(b) of the bill, we note that VHA does not appoint hearing aid specialists, and none are actively practicing in VHA as hearing aid specialists. Some audiology assistants (health technicians) are licensed as hearing aid specialists and may use these skills in performing their duties, but they were hired as health technicians and function under the scope of practice defined in their position description.

Cost estimates for this bill were not available at the time of the hearing.

H.R. 3831

If enacted, H.R. 3831 would prohibit VA from expanding VA's dialysis pilot program or creating any new dialysis capability provided by VA in any facility other than the four participating free-standing dialysis facilities until three requirements have been met: VA has implemented the pilot program at each facility for at least 2 years; VA has provided for an independent analysis of the pilot program at each facility; and VA has submitted a report to Congress. The required report must include the results of the independent analysis and a comparison of both cost and non-cost factors (such as access to care, quality of care, and Veteran satisfaction) concerning the dialysis pilot program, and must address any recommendations from the Government Accountability Office with respect to the pilot. The bill would also require the Secretary to fully utilize VA dialysis resources in existence at the time this bill is enacted, including utilization of any community dialysis provider with whom the Secretary has entered into a contract or agreement for the provision of such care.

VA fully supports using the results of our ongoing dialysis pilot program to inform the expansion of dialysis care by VA. However, VA is concerned that enactment of this bill in its current form would delay activating additional VA free-standing dialysis centers, which could adversely impact VA's efforts to optimize Veterans' dialysis care. This bill would have the effect of preventing VA from creating any new dialysis capacity until July 2015 because one of the pilot facilities (Cleveland, Ohio) did not activate until July 2013. Delaying expansion would also adversely impact VA's ability to realize potential cost savings associated with free-standing dialysis centers.

VA has already developed an evaluation plan to assess performance of each pilot. Additionally, VA has contracted with the University of Michigan-Kidney Epidemiology and Cost Center (UM-KECC) to conduct an independent analysis of the pilot facilities. In fiscal year 2013, UM-KECC produced five clinical quality and four cost reports analyzing the performance of the Raleigh and Fayetteville, North Carolina pilots. UM-KECC will be producing these reports for all four pilot sites in fiscal year 2014.

VA is ready to work with the Committee to ensure the Committee is briefed on the results of the pilot program before establishing any new free-standing dialysis centers.

Cost estimates for this bill were not available at the time of the hearing.

Draft Bill to Authorize Major Medical Facility Projects for the Department of Veterans Affairs for Fiscal Year 2014 and for Other Purposes

The draft bill represents the Administration's request for its fiscal year 2014 construction program and includes other measures useful for VA. It authorizes numerous individual medical leases proposed by VA, including those proposed in its fiscal year 2013 budget, and includes provisions aimed at facilitating more streamlined planning, construction, and leasing for joint VA/Federal-use medical facilities. The bill would also enhance VA's Enhanced-Use Lease authority and authorize major construction funds for VHA facilities in Tampa, Florida. Mr. Chairman, we appreciate your inclusion of this Administration request on the agenda today.

CONCLUSION

Mr. Chairman, this concludes my statement. Thank you for the opportunity to appear before you today. I am ready to respond to questions you or the other Members of the Subcommittee may have.